Authorization for Appeals
Release of Healthcare Information and Records

Member/Enrollee name: ______________________ Date of birth (m/d/yyyy): ____________
(First/MI/Last)

Subscriber name: ______________________ Subscriber ID number: ____________
(First/MI/Last)

AUTHORIZED REPRESENTATIVE INFORMATION:
I authorize the following representative to make an appeal on my behalf and to receive records and healthcare information regarding my appeal.

Authorized Representative's Name: Terri Hicks Phone: (941) 209- 4456
Address: ______________________ Fax: (941) 209 -5652
City: ______________________ State: ______ ZIP: ______

TYPES OF INFORMATION TO BE RELEASED: I permit Premera Blue Cross, or any of its affiliates (the "Company"), to release the following healthcare information to the person/entity listed above. I understand that the Company needs my written authorization to release any healthcare information about testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS), genetic information, or psychiatric disorders/mental illness.
Based on the box(es) I have checked below, the Company may release all diagnostic, procedural, claim, prescription or other related information and records.

- ☐ General healthcare
- ☐ Alcohol and/or Chemical dependency
- ☐ Reproductive health (including Abortion)
- ☒ Other (please specify): All patient records related to and needed for a claims appeal
- ☐ Sexually Transmitted Diseases (HIV/AIDS)
- ☐ Psychiatric disorders/Mental illness
- ☐ Genetic information

REDISCLOSURE: Information disclosed as a result of this authorization may be redisclosed by the party listed above as the recipient and may no longer be protected by state and federal privacy rules.

TIMEFRAME OF RELEASE: Unless I revoke it, this release will remain valid until the appeal process is completed, not to exceed twenty-four (24) months from the date of my signature, below.

*Signature: ______________________ Date Signed (m/d/yyyy): ____________

Print Name: ______________________

*If not the member/enrollee, I am the: ❑ Parent ❑ Legal Guardian ❑ Holder of Power of Attorney
If you are the legal guardian or holder of a power of attorney for the member/enrollee, attach legal documentation.

REVOCATION OF RELEASE: I understand that I may change my mind and revoke this release at any time.
I will do this by letting the Company know of my decision. Any change will be effective five (5) business days after the Company receives my written notice at the address listed at the bottom of this form. I understand that some or all of this information may already have been shared and that the Company will not be liable for any information already released.

NO CONDITIONS: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

When completed, you may fax this form to 425-918-5592 or mail it to:

Premera Blue Cross
Attn: Member Appeals
P.O. Box 91102
Seattle, WA 98111-9202

Please keep a copy of this release for your records.